

Pediatric Airway Assessment

This screening form may help identify patients at increased risk for sleep-related breathing disorders (e.g., obstructive sleep apnea) and/or breathing complications when undergoing sedation or general anesthesia. Such patients may benefit from referral to a medical professional for further evaluation and management.

Patient name: _____ Birthdate: ____/____/____ Gender: _____

Part I. General history

- Was your child born prematurely? NO YES (how many weeks early?): _____
- Does your child have a craniofacial syndrome? NO YES (describe): _____
- Does your child have any history of:
- a physical or neurological impairment? NO YES (describe): _____
 - low muscle tone? NO YES (describe): _____
 - respiratory disease/breathing problems? NO YES (describe): _____
 - repeated exposure to smoke? NO YES (describe): _____

Part II. Daytime indicators

- Does your child often:
- tend to breathe through the mouth? NO YES Do not know
 - wake up with headaches in the morning? NO YES Do not know
 - seem restless, unable to sit still, or always on the go? NO YES Do not know
 - interrupt others, have difficulty staying focused, or become easily frustrated? NO YES Do not know
- Do you or a teacher notice your child appears sleepy during the day? NO YES Do not know

Part III. Sleep history

- How would you rate your child's sleep? Good Fair Poor
- How many hours does your child sleep on average during a 24-hour period?: _____
- Does your child:

- fall asleep quickly? NO YES Do not know
 - snore more than half the time while sleeping? NO YES Do not know
 - snore loudly while sleeping? NO YES Do not know
 - have trouble breathing or struggle to breathe while asleep? NO YES Do not know
 - stop breathing during sleep? NO YES Do not know
 - grind his/her teeth while sleeping? NO YES Do not know
 - sleep in a seated position or with neck hyperextended? NO YES Do not know
 - occasionally wet the bed at night? NO YES Do not know
 - experience excessive sweating while sleeping? NO YES Do not know
- Is your child hard to wake up in the morning? NO YES Do not know

Signature of parent/guardian

Relationship to child

Date

This sample form, developed by the American Academy of Pediatric Dentistry, is provided as a practice tool for pediatric dentists and other dentists treating children. It was developed by experts in pediatric dentistry and is offered to facilitate excellence in practice. However, this form does not establish or evidence a standard of care. In issuing this form, the American Academy of Pediatric Dentistry is not engaged in rendering legal or other professional advice. If such services are required, competent legal or other professional counsel should be sought.

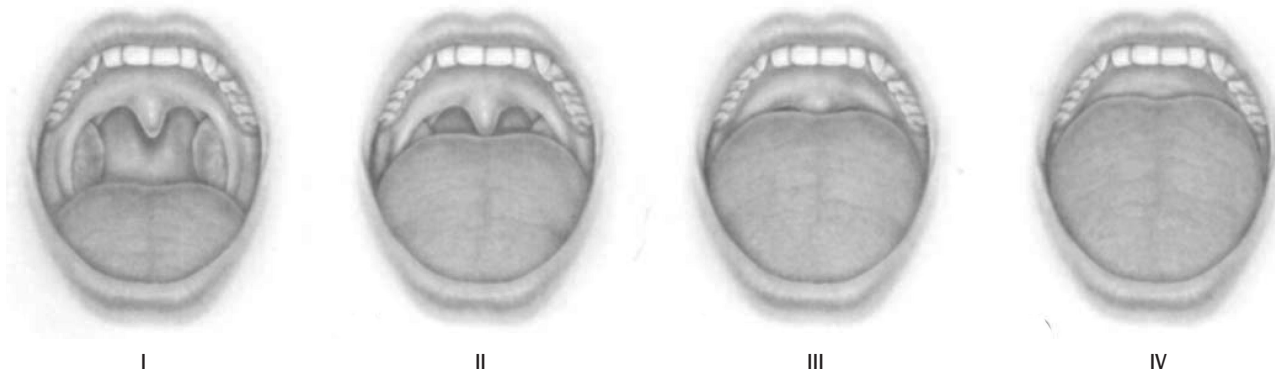
Part IV: Clinical assessment

Does the patient appear overweight? NO YES BMI _____ Percentile _____

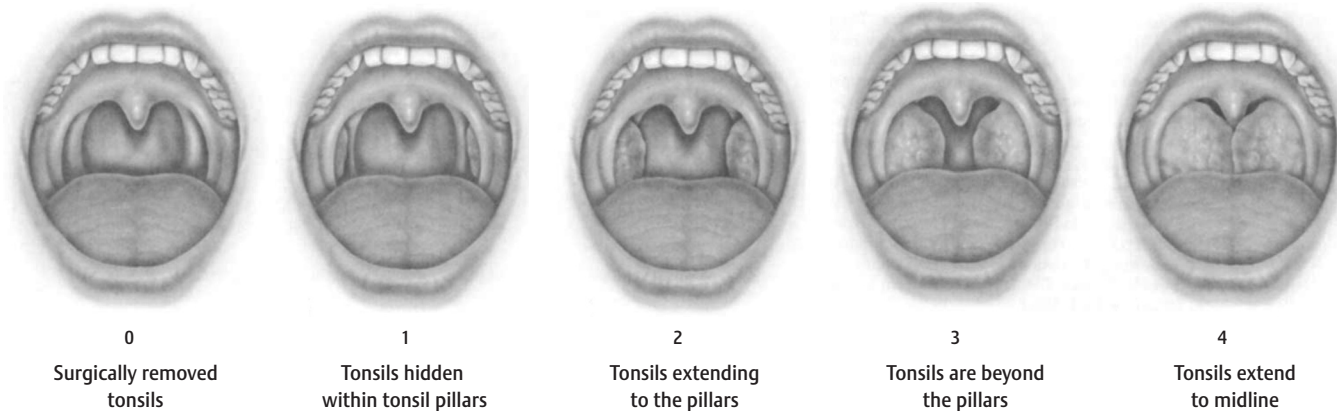
Does the patient have

- limited neck mobility? NO YES
- micro/retrognathia? NO YES
- limited oral opening? NO YES
- lip incompetency? NO YES
- an anterior open bite? NO YES
- a narrow maxillary arch with vaulted palate? NO YES
- a posterior crossbite? NO YES
- macroglossia? NO YES

Which Modified Mallampati Classification¹ best describes the patient? I II III IV



Which tonsillar grade¹ (adapted) best describes the patient? 0 1 2 3 4



Is a medical referral indicated? NO YES

Comments: _____

Doctor's signature

Date

Reference:

1. Friedman M, Tanyeri H, La Rosa M, et al. Clinical predictors of obstructive sleep apnea. *Laryngoscope* 1999;109(12):1901-7.

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